GEHA.

**Corporate Medical Policy**

Ablative and Surgical Treatment for Venous Insufficiency

**Table of Contents**



## Description of Procedure

A variety of treatment modalities are available to treat varicose veins/venous insufficiency, including surgical approaches, thermal ablation, and sclerotherapy. The application of each of these treatment options is influenced by the severity of the symptoms, the type of vein, the source of venous reflux, and the use of other (prior or concurrent) treatments.

## Benefit Application

This medical policy relates only to the services or supplies described herein. Please refer to the member's benefit booklet for availability of benefits.

## Policy Statement

Ablative and surgical treatment for venous insufficiency is covered when it is determined to be medically necessary when the medical criteria and guidelines hereafter mentioned have been demonstrated and documented.

## When treatment for Ablative and Surgical Treatment for Venous Insufficiency is covered:

A. Surgical and/or ablative interventions (ligation/stripping, ablation, microfoam sclerotherapy) to treat incompetence of the greater saphenous vein (GSV) and long or small saphenous vein (LSV or SSV) may be considered if the following are met per lower extremity **(Ligation/excision 37700, 37718, 37722, 37735, 37780, 37785; Radiofrequency 36475, 36476; Endovenous laser ablation 36478, 36479; Sclerotherapy using ultrasound guidance and a microfoam sclerosant (Varithena) 36465, 36466**,

1. Ultrasound documented saphenous reflux with duration of 500 milliseconds or greater in the vein to be treated; and vein size is 4.5 mm or greater in diameter measured by ultrasound **immediately below** the saphenofemoral or saphenopopliteal junction (not the valve diameter at the junction), and
2. Ulceration secondary to venous stasis, or
3. Recurrent superficial thrombophlebitis, or
4. Recurrent bleeding from a ruptured superficial varicosity, or

5. Persistent pain, swelling, itching, burning, or other symptoms are associated with saphenous reflux, and
6. The symptoms significantly interfere with activities of daily living, and
7. Conservative management including compression therapy (20-30mm Hg) for at least 3 months has not improved the symptoms

B. Surgical and/or ablative interventions for accessory saphenous veins (ASV) of the same leg may be considered medically necessary when performed either at the same time or following prior treatment (surgical or ablation) to the proximal saphenous veins and with documentation of the following indications:

1. Ultrasound documented saphenous reflux with duration of 500 milliseconds or greater in the vein to be treated, and
2. Ulceration secondary to venous stasis, or
3. Recurrent superficial thrombophlebitis, or
4. Recurrent bleeding from a ruptured superficial varicosity, or
5. Persistent pain, swelling, itching, burning, or other symptoms are associated with saphenous reflux, and
6. The symptoms significantly interfere with activities of daily living, and
7. Conservative management including compression therapy (20-30mm Hg) for at least 3 months has not improved the symptoms.

C. Surgical ligation or endovenous radiofrequency or laser ablation of incompetent perforator veins may be considered medically necessary as a treatment of leg ulcers associated with chronic venous insufficiency when the following conditions have been met:

1. There is perforator reflux demonstrated on ultrasound with duration of 350 milliseconds or greater in the vein to be treated, and
2. The vein diameter is 3.5 mm or greater, and
3. The superficial saphenous veins (great, small, or accessory saphenous and symptomatic varicose tributaries) have been previously eliminated, and
4. Ulcers have not resolved following combined superficial vein treatment and compression therapy for at least 3 months, and
5. The venous insufficiency is not secondary to deep venous thromboembolism.

Perforator veins, even with reflux demonstrated, do not require surgery or ablation unless persistent venous ulcers are present or a history of ulcers. Frequently the incompetence in the perforator will improve with treatment of the saphenous vein.

D. Phlebectomy procedures are considered medically necessary for the treatment of the residual tributary, perforator, or accessory veins in the saphenous distribution if the following criteria are met **(37765, 37766, 37799)**:

1. Phlebectomy must be performed along with an approved ablation, ligation/stripping, or microfoam sclerotherapy to a primary vessel of the same leg, or
2. Phlebectomy (in conjunction with one of the above accompanying procedures) has previously been performed on the same leg, and

3. Initial Phlebectomy treatment consists of up to two multiple stab phlebectomy incisions in each affected extremity (i.e., a total of four multiple stab incisions if both legs are affected)

E. Additional Phlebectomy procedures for persons with persistent or recurrent symptoms are considered medically necessary for the treatment of the residual tributary, perforator, or accessory veins in the saphenous distribution if the following criteria are met **(37765, 37766, 37799)**:

1. Symptomatic varicosities persist or have recurred following a previously completed phlebectomy, and
2. Ultrasound documented saphenous reflux with duration of 500 milliseconds or greater in the vein to be treated, and
3. Ulceration secondary to venous stasis, or
4. Recurrent superficial thrombophlebitis, or
5. Recurrent bleeding from a ruptured superficial varicosity, or
6. Persistent pain, swelling, itching, burning, or other symptoms are associated with saphenous reflux, and
7. The symptoms significantly interfere with activities of daily living, and
8. Conservative management including compression therapy (20-30mm Hg) has not improved the symptoms, and
9. Up to two multiple stab phlebectomy incisions in each affected extremity (i.e., a total of four multiple stab incisions if both legs are affected).

E. Sclerotherapy is considered medically necessary for the treatment of residual tributary veins when a diameter of greater than 2.5 mm is present upon initial ultrasound or remains present after treatment as evidence by a post treatment ultrasound of the great saphenous vein (GSV), long saphenous vein (LSV) OR small saphenous vein (SSV) and/or anterior accessory saphenous vein (ASV). **(36470, 36471)**

1. Veins less than 2.5 mm are considered cosmetic,
2. Sclerotherapy as the sole treatment of varicose veins without associated treatment of the primary veins is not considered standard of care and is thus not covered as medically necessary,
3. A maximum of 3 sessions per leg will be allowed following primary treatment only when the above criteria are met and the plan of care is associated with covered treatments of one or more primary veins in the target extremity.

**When treatment is not covered:**

GEHA considers the following vein therapy procedures as experimental and investigational and are therefore not covered. This includes, but is not limited to, the following:

1. Procedures for which the above criteria is not met, and/or
2. Endomechanical or Mechanicochemical Ablation (MOCA) **(36473, 36474),** and/or
3. Photothermal Sclerosis

GEHA considers the following vein therapy procedures as cosmetic and are therefore not covered. This includes, but is not limited to, the following:

1. Procedures for when the above criteria are not met, and/or
2. Veins less than 2.5 mm are considered cosmetic,

3. All treatments for spider veins (telangiectasia) are considered cosmetic,
4. Asclera polidocanol injection. This medication is used for spider veins and reticular veins. **(36468)**
5. Congenital venous malformations in patients ≥18, unless a functional deficit exists

**Physician Documentation**

Provide the following documentation with your request for members:

- Current history and physical
- All supporting medical records documenting clinical findings, including:
    - Signs and symptoms, including member's complaint and duration of severity of the condition, and
    - Documentation of symptoms that are causing functional impairment, if present, and
    - Physical findings, and
    - Radiology and imaging study reports.
- Doppler and duplex scanning report with clear results completed pre-treatment showing valve incompetence with reflux and diameter of veins
- Clinical records documenting the following:
    - Activities the member must modify or cannot perform due to varicose vein conditions,
    - Documentation of conservative and adjunctive measures, including duration and outcome. This would include elevation of the extremities, exercise, avoidance of prolonged immobility, weight loss and graded compression stockings (at least 20-30mmHg pressure) for 3 months prior to procedure,
    - Plan of care for treatment of the varicose vein(s).

**Policy Guidelines**

GEHA considers the following as absolute contraindications to venous surgery and/or ablation:

A. Acute deep vein thrombosis (DVT)

B. Acute superficial phlebitis

C. Acute infections at puncture sites

D. Deep venous obstruction if the vein to be treated is a functional collateral

E. Pregnancy or nursing

F. Extreme arterial insufficiency (Fan et. al., 2015).

The Society for Vascular Surgery (SVS) and the American Venous Forum (AVF) (Gloviczki et. al., 2011) have developed clinical practice guidelines for the care of patients with varicose veins of the lower limbs and pelvis. The document also includes recommendations on the management of superficial and perforating vein incompetence in patients with associated, more advanced chronic venous diseases (CVDs), including edema, skin changes, or venous ulcers. It is recommended that in patients with varicose veins or more severe CVD, a complete history and detailed physical examination are complemented by duplex ultrasound scanning of the deep and superficial veins (GRADE 1A). The CEAP

classification is used for patients with CVD (GRADE 1A) and that the revised Venous Clinical Severity Score is used to assess treatment outcome (GRADE 1B). Compression therapy for patients with symptomatic varicose veins (GRADE 2C) but recommend against compression therapy as the primary treatment if the patient is a candidate for saphenous vein ablation (GRADE 1B). Compression therapy as the primary treatment to aid healing of venous ulceration (GRADE 1B). To decrease the recurrence of venous ulcers, it is recommended to use ablation of the incompetent superficial veins in addition to compression therapy (GRADE 1A). For treatment of the incompetent great saphenous vein (GSV), we recommend endovenous thermal ablation (radiofrequency or laser) rather than high ligation and inversion stripping of the saphenous vein to the level of the knee (GRADE 1B). We recommend phlebectomy or sclerotherapy to treat varicose tributaries (GRADE 1B) and suggest foam sclerotherapy as an option for the treatment of the incompetent saphenous vein (GRADE 2C). We recommend against selective treatment of perforating vein incompetence in patients with simple varicose veins (CEAP class C(2); GRADE 1B), but we suggest treatment of pathologic perforating veins (outward flow duration ≥500 ms, vein diameter ≥3.5 mm) located underneath healed or active ulcers (CEAP class C(5)-C(6); GRADE 2B). We suggest treatment of pelvic congestion syndrome and pelvic varices with coil embolization, plugs, or transcatheter sclerotherapy, used alone or together.

The American College of Phlebology Guidelines Committee (2017) performed a systematic review of the literature regarding the clinical impact and treatment of incompetent accessory saphenous veins. Using an accepted process for guideline developments, we developed a consensus opinion that patients with symptomatic incompetence of the accessory great saphenous veins (anterior and posterior accessory saphenous veins) be treated with endovenous thermal ablation (laser or radiofrequency) or ultrasound-guided foam sclerotherapy to eliminate symptomatology (Recommendation Grade 1C).

Position statement American Vein and Lymphatic Society (January 2019): The current published evidence, and FDA approval, support Varithena as a safe, effective, and clinically meaningful option for the treatment of superficial venous disease when it is deemed to be medically necessary. The American Vein and Lymphatic Society, on behalf of our members and their patients, request that carriers cover Varithena for all FDA-approved indications with reimbursement commensurate with CMS valuation, or by contract with private payers. Attached are the clinical data and references to substantiate our recommendations.

**Background**

Varicose veins are a common condition. In adult populations visible varicose veins are present in approximately 23% of US adults (Hamdan, 2012). The venous system of the lower extremities consists of the superficial veins, including the greater (GSV) and lesser/small (LSV OR SSV) saphenous, and accessory veins (ASV), the deep system (popliteal and femoral veins), and perforator veins that cross through the fascia and connect the deep and superficial systems. One-way valves are present within all veins to direct the return of blood up the lower limb. Since venous pressure in the deep system is generally greater than that of the superficial system, valve incompetence at any level may lead to backflow with pooling of blood in superficial veins. Varicose veins with visible varicosities may be the only sign of venous reflux, although itching, heaviness, tension, and pain may also occur. Chronic venous insufficiency secondary to venous reflux can lead to thrombophlebitis, leg ulcerations, and hemorrhage.

Most varicose veins do not require medical treatment. In some cases, however, the circulation may be hindered enough to cause swelling of the foot and ankle, discomfort, a tingling sensation, or a feeling of

heaviness. For most people with varicose veins, wearing specially fitted elastic stockings is all that is needed. Treatment of venous reflux/venous insufficiency is aimed at reducing abnormal pressure transmission from the deep to the superficial veins. Conservative medical treatment consists of elevation of the extremities, exercise, avoidance of prolonged immobility, weight loss and graded compression stockings (O'Meara et. al., 2012). Conventional surgical treatment consists of identifying and correcting the site of reflux by ligation of the incompetent junction followed by stripping of the vein to redirect venous flow through veins with intact valves. While most venous reflux is secondary to incompetent valves at the saphenofemoral or saphenopopliteal junctions, reflux may also occur at incompetent valves in the perforator veins or in the deep venous system.

When conservative measures are insufficient to manage the symptoms of venous reflux, treatment typically consists of the following:

1. Identification of valvular incompetence via diagnostic Doppler ultrasound assessment,
2. Control of the most proximal point of reflux, via surgical intervention: ligation at the incompetent saphenofemoral or saphenopopliteal junction as the classic standard, therefore we can only allow one ablative procedure to the same vein at the same time.
3. Removal of the incompetent superficial vein from circulation, such as via stripping of a saphenous vessel,
4. Removal of varicose tributaries by phlebectomy or injection sclerotherapy.

Minimally invasive alternatives to ligation and stripping include: sclerotherapy, transilluminated powered phlebotomy and thermal ablation using cryotherapy, high frequency radiowaves or laser energy.

**Endovenous Catheter Ablation (EVCA)**

This is a non-specific term that refers to catheter based minimally invasive alternatives to surgical stripping such as radiofrequency endovenous occlusion (i.e. VNUS procedure) and endovenous laser ablation of the saphenous vein (EVLA). These procedures are generally considered equally effective in the treatment of venous insufficiency of the GSV. Both modalities use thermal energy to seal off the diseased vein via an intraluminal catheter system. In a randomized controlled trial by Brittenden et. al. (2015) 798 patients with primary varicose veins undergoing foam sclerotherapy, endovenous laser ablation and surgery for varicose veins. It was concluded, in regard to an estimated 5-year cost-effectiveness EVLA should be considered as the treatment of choice for suitable patients.

**Microfoam Chemical Ablation- (polidocanol injectable foam)**

Varithena (polidocanol injectable foam) is a sclerosing agent indicated for the treatment of incompetent great saphenous veins, accessory saphenous veins, and visible varicosities of the great saphenous vein system above and below the knee. Varithena is used to address the symptoms of superficial venous incompetence and the appearance of visible varicosities. Varithena is contraindicated in patients with a known allergy to polidocanol and acute thromboembolic disease (Biocompatibles Inc., n.d.).

In 2017, Gibson et. al. conducted a A multicenter, randomized, placebo-controlled study to evaluate the efficacy and safety of Varithena® (polidocanol endovenous microfoam 1%) for symptomatic, visible varicose veins with saphenofemoral junction incompetence. After studying

77 patients, it was concluded that Varithena provided significantly greater symptom relief and improvement in leg appearance compared with placebo. Adverse events were generally mild and transient.

**Surgical Ligation and Stripping**

This has been the standard of surgical care for refractory venous insufficiency prior to the introduction of alternative procedures. Two incisions are made. One at the top of the leg just below the groin and one behind the knee joint or ankle. The vein is then tied or clamped off at the top incision using a technique called vein litigation. A long wire is sent through the lower incision up through the vein, and at the lower end a button-like cap is attached to the wire. This allows the entire vein to be pulled out through the incision near the groin. An updated Cochrane review from 2014 compared EVLA and RFA and foam sclerotherapy versus ligation/stripping for saphenous vein varices. For EVLA versus surgery, there were no significant differences between the treatment groups for clinician noted or symptomatic recurrence, or for recanalization. This was confirmed by Britten et al.

**Ambulatory Phlebectomy (including Transilluminated Powered Phlebectomy (TIPP) or (TriVex))**

Ambulatory phlebectomy, also called stab avulsion, is one accepted surgical method for removal of varicose tributaries. TIPP is similar to ambulatory phlebectomy but slightly more invasive. It is performed on an outpatient basis in an operating room under light anesthesia. After making two small incisions near the varicose vein, the surgeon inserts a tumescent cannula illuminator (TCI) that contains a fiber optic light that makes the veins easily visible. Fluid containing a local anesthetic is infused under the skin, loosening the vein from the surrounding tissue. A vein remover instrument is guided to the vein, which is suctioned into the instrument where it is cut into small pieces and removed. Due to the large amount of local anesthetic used, patients usually awake without any pain and are able to return home in about an hour. While TIPP had the advantage of fewer surgical incisions, it was associated with a more prolonged recovery due to more extensive bruising, prolonged pain, and reduced early postoperative quality of life. The current literature does not show an advantage of TIPP over conventional treatment referred to within this policy (Chetter et. al., 2006; Luebke et. al. 2008).

**Sclerotherapy and Ultrasound Guided Foam Sclerotherapy**

Sclerotherapy effectively treats varicose and spider veins. It's often considered the treatment of choice for small varicose veins. Sclerotherapy involves injecting a solution directly into the vein. The sclerotherapy solution causes the vein to scar, forcing blood to reroute through healthier veins. The collapsed vein is reabsorbed into local tissue and eventually fades (Mayo Clinic, 2019).

The 2013 MAGNA trial, studied 223 consecutive patients (240 legs) with greater saphenous vein reflux who were randomized to EVLA, ligation and stripping, or physician compounded foam sclerotherapy (1 cc aethoxysclerol 3%). At 1-year follow-up, the anatomic success rate of foam sclerotherapy (72.2%) was inferior to both EVLA and stripping. However, it has been shown to be effective for adjunctive treatment of symptomatic saphenous veins, varicose tributaries,

accessory, and perforator veins 2.5 mm or greater in diameter for persons who have undergone EVLA or similar procedures for incompetence at the saphenofemoral junction or saphenopopliteal junction.

Nesbitt et. al. (2014) conducted research to determine whether endovenous ablation (radiofrequency and laser) and foam sclerotherapy have any advantages or disadvantages in comparison with open surgical saphenofemoral ligation and stripping of great saphenous vein varices. A total of 13 studies were evaluated with a combined total of 3081 randomized patients. It was concluded that currently available clinical trial evidence suggests that ultrasound-guided foam sclerotherapy, endovenous laser therapy and radiofrequency ablation are at least as effective as surgery in the treatment of great saphenous varicose veins

**Asclera polidocanol injection**
GEHA considers Asclera polidocanol injection as cosmetic; although Asclera has been approved by the Food and Drug Administration (FDA) for the treatment of telangiectasias and reticular veins less than 3 mm in diameter, treatment of these small veins is considered cosmetic.

**Endomechanical or Mechanicochemical Ablation (MOCA)**
This technique is also referred to as Endomechanical ablation, mechanico-chemical endovenous ablation (MCEA) and mechanically enhanced endovenous chemical ablation (MEECA) (including but not limited to ClariVein, VenaSeal, etc). Mechanochemical endovenous ablation utilizes both sclerotherapy and mechanical damage to the lumen. Following ultrasound imaging, a disposable catheter with a motor drive is inserted into the distal end of the target vein and advanced to the saphenofemoral junction. A wire rotates within the lumen of the vein, abrading the lumen. At the same time, a liquid sclerosant is infused near the rotating wire. It is proposed that mechanical ablation allows for better efficacy of the sclerosant, without the need for the tumescent anesthesia used in radiofrequency ablation or endovenous laser ablation (Mueller & Raines, 2013). Initial studies appear to indicate that this procedure results in less post-operative pain with comparable outcomes, further long term studies remain to be completed before considering this procedure to be non-investigational (Bootun, et. al., 2016; Kim et. al. 2016).

**Photothermal Sclerosis**
Also referred to as an intense pulsed light source, e.g., the PhotoDerm VascuLight, VeinLase. This procedure is used to treat small veins such as small varicose veins and spider veins. Photothermal Sclerosis is considered cosmetic because such small veins do not cause pain, bleeding, ulceration, or other medical problems.

**Endovenous Cryoablation**
Cryoablation uses extreme cold to cause injury to the vessel. Klem et. al. (2009) concluded that cryo-stripping accounts for numerous procedural failures and hence residual GSV in patients. The Aberdeen Varicose Vein Questionnaire (AVVQ) showed small but significantly better results for patients after a conventional stripping. Thus, cryo-stripping has no benefits over conventional stripping. Disselhoff et. al. (2011) reported no significant difference was demonstrated in late outcome after EVLA or cryostripping in patients with great saphenous varicose veins.

**Perforator vein surgery**
Subfascial endoscopic perforator vein surgery (SEPS) utilizes techniques to interrupt incompetent perforators under direct vision using an endoscopic video camera and instrumentation placed through small ports remote from the active ulcer or area of diseased skin (Kalra & Gloviczki, 2002).

## Regulatory Status

Ablative and surgical treatment for venous insufficiency is a procedure and, as such, is not subject to regulation by the FDA.

However, the FDA does regulate manufacturing practices and use of devices and drugs for such procedures. These include but are not limited to the ClariVein infusion catheter (approved K071468), VenaSeal Closure System (PMA P140018), and Varithena (approved NDA 205098).

## Coding Guidelines

CPT codes 36465 and 36466 describe injection of non-compounded foam sclerosant with ultrasound-guided outflow compression maneuvers. CPT codes 36465 and 36466 may not be used to report injection of self-prepared or self-compounded sclerosant (see codes 36470 and/or 36471 for self-compounded or non-compounded sclerosant injections). CPT codes 36465 and 36466 include ultrasound guidance and 76942 should not be reported in conjunction with 36465 or 36466. CPT codes 36465 and 36466 are reported one per extremity per day and should not be reported together for the same extremity. 36465 is reported for a single vein. 36466 is reported for multiple veins (any number of multiple veins) within the same extremity (AMA CPT Assistant, March 2018).

CPT codes 36470 and 36471 describe the puncture of the vein and injection of sclerosing agent through the needle. These codes are used to report treatment of abnormal veins larger than spider veins, but smaller than varicosities in main veins such as the saphenous vein (AMA CPT Assistant, October 2014). CPT code 36470 should be used when only one vein is injected on a given date of service. CPT 36471 may be reported once per extremity per session, regardless of the number of veins treated, when two or more veins are treated. 36470 and 36471 should not both be reported for the same extremity and session. When ultrasonic guidance is used, 76942 may be reported. (AMA CPT Assistant, November 2015). Do not report 37241 in the same surgical field as 36470/36471. Local and tumescent (instillation of saline with lidocaine and epinephrine) anesthesia, when provided, is included in the work described by these codes and may not be billed separately (AMA CPT Assistant, October 2014). Do not report 29581 in conjunction with 36470/36471 (AMA CPT Assistant, March 2018).

CPT codes 36475 and 36476 describe procedures that treat incompetent extremity veins by ablation with radiofrequency energy used to heat and seal the vein closed, which is applied directly in the lumen of the vein via percutaneous catheterization. These codes are typically performed using ultrasound guidance and monitoring, local and tumescent anesthesia, and percutaneous access typically achieved using ultrasound guidance. All imaging guidance (including ultrasound and/or fluoroscopy), vessel access, catheterization, selection, and closure are included in the word described by codes 36475 and 36476. CPT codes 36475 and 36476 include all imaging guidance and should not be reported with 29581, 29582, 36000, 36002, 36005, 36410, 36425, 36478, 36479, 37241-37244, 75894, 76000, 76001, 76934, 76942, 76998, 77022, 93970, 93971 in the same surgical field (AMA Assistant, October 2014). Code

36475 should be used to report the first vein treated during the session. Code 36476 should be reported in conjunction (list separately in addition to code for primary procedure) with 36475 when multiple (second/subsequent) veins are treated. Code 36476 may only be listed once per extremity, per session; the add-on code is reported once, irrespective of the number of veins treated. No additional reporting occurs after the second vein is treated. (AMA CPT Assistant, July 2010).

CPT codes 36478 and 36479 describe procedures that treat incompetent extremity veins by ablation with laser energy used to heat and seal the vein closed, which is applied directly in the lumen of the vein via percutaneous catheterization. These codes are typically performed using ultrasound guidance and monitoring, local and tumescent anesthesia, and percutaneous access typically achieved using ultrasound guidance. All imaging guidance (including ultrasound and/or fluoroscopy), vessel access, catheterization, selection, and closure are included in the word described by codes 36475 and 36476. CPT codes 36478 and 36479 include all imaging guidance and should not be reported with 29581, 29582, 36000, 36002, 36005, 36410, 36425, 36475, 36476, 37241, 75894, 76000, 76001, 76937, 76942, 76998, 77022, 93970, 93971 in the same surgical field (AMA Assistant, October 2014). Code 36475 should be used to report the first vein treated during the session. Code 36479 should be reported in conjunction (list separately in addition to code for primary procedure) with 36478 when multiple (second/subsequent) veins are treated. Code descriptor for code 36479 states, "second and subsequent veins treated in a single extremity, each through separate access sites," indicating that the second, third, fourth, etc, vein(s) are represented in code 36479. No additional reporting occurs after the second vein is treated. (AMA CPT Assistant, July 2012).

When performed in the office setting, all required supplies and equipment (eg, sclerosant, catheters, tumescent anesthesia, “kits”) are included in codes 36473-36476, 36478, and 36479 and may not be reported separately. In addition, application of compression dressing(s) (eg, compression bandages/stockings) is also included in codes 36473-36476, 36478, and 36479 when performed, and may not be reported separately (AMA CPT Assistant, March 2018).

CPT codes 36482 and 36483 describe chemical adhesive saphenous ablation. 36482 and 36483 may only be reported once per extremity per day (AMA CPT Assistant, February 2019). 36483 may be reported in conjunction with 36482. 36482 and 36483 may not be reported in conjunction with 29581, 36000, 36002, 36005, 36410, 36425, 36475, 36476, 36478, 36479, 37241, 75894, 76000, 76001, 76937, 76942, 76998, 77022, 93970, 93971 in the same surgical field. When performed in the office setting, all required supplies and equipment (eg sclerosant, catheters, tumescent anesthesia, “kits”, application of compression dressing(s) [eg, compression bandages/stockings]) are included and may not be reported separately. (AMA CPT Assistant, March 2018)

**The following codes are for reference purposes only and do not imply that the service is covered or non-covered. Applicable codes include but are not limited to:**

| CPT/HCPCS Codes | Definition |
|---|---|
| **Sclerotherapy using Ultrasound Guidance and a Microfoam Sclerosant** | |
| 36465<br>(e.g. Varithena) | Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging |

| | |
|---|---|
| | guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein) |
| 36466<br>(e.g. Varithena) | Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg |
| **Sclerotherapy** | |
| 36470 | Injection of sclerosant; single incompetent vein (other than telangiectasia) |
| 36471 | Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg |
| **Radiofrequency Ablation** | |
| 36475 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated |
| 36476 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) |
| **Endovenous Laser Ablation** | |
| 36478 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated |
| 36479 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) |
| **Ligation and Excision** | |
| 37700 | Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions |
| 37718 | Ligation, division, and stripping, short saphenous vein |
| 37722 | Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below |
| 37735* | Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia |
| 37760* | Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open, 1 leg |
| 37761* | Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg |
| 37780 | Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure) |
| 37785* | Ligation, division, and/or excision of varicose vein cluster(s), one leg |
| **Ambulatory Phlebectomy** | |
| 37765 | Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions |
| 37766 | Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions |

| | |
|---|---|
| 37799** | Unlisted procedure; vascular surgery |
| 37799** | Unlisted procedure and J3490 unclassified drug; used for foam sclerotherapy |
| **Embolization procedures and Radiological Supervision** | |
| 37241* | Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (e.g., congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles) |
| 37244* | Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation |
| 75894* | Trans catheter therapy, embolization, any method, radiological supervision and interpretation |
| 76942* | Ultrasonic guidance for needle placement (e.g. biopsy, aspiration, injection and localization device), imaging supervision and interpretation [not covered when performed solely to guide the needle or introduce sclerosant into the varicose veins |
| **Endovascular Ablation Cyanoacrylate Adhesive** | |
| 36482<br>(e.g. VenaSeal Closure System) | Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (e.g., cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated |
| 36483<br>(e.g. VenaSeal Closure System) | Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (e.g., cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) |

* Prior authorization is not required when procedures are performed at medically necessary frequency

**Operative report with description of unlisted procedures is required

**CPT or HCPCS CODE(S) NOT COVERED FOR INDICATIONS LISTED WITHIN THIS COVERAGE POLICY:**

| | |
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| **Sclerotherapy for Treatment of Telangiectasia** | |
| 36468 | Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk |
| **Endomechanical Ablative Approach** | |

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| 36473<br>(e.g. MOCA) | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated |
| 36474<br>(e.g. MOCA) | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) |

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**Policy implementation and updates:**

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| Dec 2019 | Background content added, referencing updates. No changes to policy coverage. |
| April 2020 | Formatting update; coverage criteria clarification |
| May 2021 | No changes in coverage. |
| Feb 2022 | Clarification of Phlebectomy criteria language. Inclusion of coding guidelines. |
| June 2022 | Clarified that phlebectomy is covered for perforator and accessory veins when criteria are met. Added embolization, radiological supervision, and cyanoacrylate ablation as covered procedures. Clarified that congenital anomaly requires functional deficit when patient is 18 or older. Noted procedures covered under policy which do not require prior authorization. Added coding guide for quantities of procedure codes billable. |
| June 2023 | Removed "**Endovenous ablation by chemical adhesive e.g. cyanoacrylate (VenaSeal) 36482, 36483):** For section E. Sclerotherapy added "upon initial ultrasound" and "as evidence by a post treatment ultrasound." Added, "therefore we can only allow one ablative procedure to the same vein at the same time" to Control of the most proximal point of reflux, via surgical intervention: ligation at the incompetent saphenofemoral or saphenopopliteal junction as the classic standard. Updated the following CPT Code descriptions: 36470 - Injection of sclerosant; single incompetent vein (other than telangiectasia), 36471 - Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg, 36476 - Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure), 36479 - Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure), 37799 - Unlisted procedure, vascular surgery, 36468 - Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk |

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| March 2024 | Removed Please complete the authorization form available HERE and return with ALL the following documentation: from Physician Documentation. Added under Physician Documentation Provide the following documentation with your request for members: |